



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MANUEL RAMIREZ MD
CENTER FOR PAIN RELIEF
9080 HARRY HINES SUITE 110
DALLAS TX 75235

Respondent Name

TPCIGA FOR RELIANCE INSURANCE

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-11-3011-01

MFDR Date Received

MAY 6, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has denied payment of Code J7799 KD for all of the dates of service listed above. On the 10/06/10 date of service the code was denied stating, 'payment for this service is excluded by Medicare payment policy regulation adopted by TDI-DWC', and on the 6/09/10 or documented, we are unable to make a payment without a clearer description of the service performed'...The carrier paid this code for date of service 8/10/2009 with no question. I have provided both copies of the EOR (Attachment 1) and our original claim (Attachment 2) filed for the 8/10/2009 date of service. As you will see on the claim form – we have billed this code the same as we have for previous dates. As you can see, the carrier is inconsistent with processing and payment of our claims. We have filed our claim with the same information each time, but the carrier has not processed consistently."

Amount in Dispute: \$1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in the response packet.

Response Submitted by: Specialty Risk Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 9, 2010 October 6, 2010	Pain Pump Refill - HCPCS Code J7799 KD	\$500.00 X 2 = \$1,000.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers'

compensation professional medical services provided on or after March 1, 2008.

3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 16-The unlisted or BR service was not sufficiently identified or documented. We are unable to make a payment without a clearer description of the service performed.
- W1-Workers compensation fee schedule adjustment. Payment for this service is excluded by Medicare policy regulation as adopted by TDI-DWC.
- 16-Claim/service lacks info which is needed for adjudication. A valid NDC number, Rx number, quantity and strength for drug is needed for reimbursement.

Issues

1. Did the requestor support position that billing is in accordance with Medicare policy?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason codes "16 and W1."
HCPCS code J7799 is defined as "NOC drugs, other than inhalation drugs, administered through DME."

Trailblazers Health Enterprises published an article titled "Part B Drugs Used in an Implantable Infusion Pump" in March 2010. This article provided coding guidelines that indicate that "...compounded drugs used in an implantable infusion pump must be billed using Not Otherwise Classified (NOC) code J7799KD, whether a single drug or a combination of drugs is administered." A review of the submitted medical bill supports the requestor's position that HCPCS code J7799KD was billed in accordance with Medicare policy.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203 (b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 Texas Administrative Code §134.203 (d)(1) (2) and (3) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

The Division finds that HCPCS code J7799KD does not have a fee listed in DMEPOS fee schedule nor a Medicaid rate.

28 Texas Administrative Code §134.203 (f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1(f) requires in pertinent part, that reimbursement shall: "(1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It

further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:

- The requestor states in the position summary that “As you will see on the claim form – we have billed this code the same as we have for previous dates. As you can see, the carrier is inconsistent with processing and payment of our claims.”
- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not submit documentation to support that reimbursement of \$500.00 is fair and reasonable.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

07/11/2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.